

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Policy and Operations

4 (Amendment)

5 907 KAR 1:631. [~~Reimbursement of~~] Vision Program reimbursement provisions and re-  
6 quirements[~~services~~].

7 RELATES TO: KRS 205.520, 42 C.F.R. 440.40, 440.60, 447 Subpart B, 42 U.S.C.  
8 1396a-d

9 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

10 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family  
11 Services, Department for Medicaid Services has responsibility to administer the Medi-  
12 caid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to  
13 comply with any requirement that may be imposed, or opportunity presented, by federal  
14 law to qualify for federal Medicaid funds[~~for the provision of medical assistance to Ken-~~  
15 ~~tucky's indigent citizenry~~]. This administrative regulation establishes Medicaid program  
16 reimbursement provisions and requirements for vision services provided to a Medicaid  
17 recipient who is not enrolled in a managed care organization[~~provisions for vision ser-~~  
18 ~~vices~~].

19 Section 1. Definitions. (1) "Department" means the Department for Medicaid Ser-  
20 vices or its designated agent.

21 (2) "Enrollee" means a recipient who is enrolled with a managed care organization.

1 (3) "Federal financial participation" is defined by 42 C.F.R. 400.203.

2 (4) "Healthcare common procedure coding system" or "HCPCS" means a collection  
3 of codes acknowledged by the Centers for Medicare and Medicaid Services that repre-  
4 sent procedures or items.

5 (5) "Managed care organization" means an entity for which the Department for Medi-  
6 caid Services has contracted to serve as a managed care organization as defined in 42  
7 C.F.R. 438.2.

8 ~~(6) "Index" means an indication of changes in health care costs from year to year de-~~  
9 ~~veloped by Global Insight.~~

10 ~~(3) "Medically necessary" or "medical necessity" means that a covered benefit is de-~~  
11 ~~termined to be needed in accordance with 907 KAR 3:130.~~

12 (7)[(4)] "Ophthalmic dispenser" means an individual who is qualified to engage in the  
13 practice of ophthalmic dispensing in accordance with KRS 326.030 or KRS 326.040.

14 (8) "Optometrist" is defined by KRS 311.271.

15 (9) "Provider" is defined by KRS 205.8451(7).

16 (10) "Recipient" is defined by KRS 205.8541(9)[a physician, optician, or optometrist,  
17 ~~who is licensed to prepare and dispense lenses and eyeglasses in accordance with an~~  
18 ~~original, written prescription.~~

19 ~~(5) "Resource-based relative value scale unit" or "RBRVS unit" means a value based~~  
20 ~~on the service which takes into consideration the practitioners' work, practice expenses,~~  
21 ~~liability insurance, and a geographic factor based on the prices of staffing and other re-~~  
22 ~~sources required to provide the service in an area relative to national average price].~~

23 Section 2. General Requirements. (1)(a) For the department to reimburse for a vision

1 service or item, the service or item shall be:

2 1. Provided:

3 a. To a recipient; and

4 b. By a provider who:

5 (i) Is enrolled in the Medicaid program pursuant to 907 KAR 1:672;

6 (ii) Except as established in paragraph (b) of this subsection, is currently participating  
7 in the Medicaid program pursuant to 907 KAR 1:671; and

8 (iii) Is authorized by this administrative regulation to provide the given service or item;

9 2. Covered in accordance with 907 KAR 1:632;

10 3. Medically necessary;

11 4. A service or item authorized within the scope of the provider's licensure; and

12 5. A service or item listed on the Department for Medicaid Services Vision Program

13 Fee Schedule.

14 (b) In accordance with Section 3(3) of 907 KAR 17:010, a provider of a service to an  
15 enrollee shall not be required to be currently participating in the Medicaid program if the  
16 managed care organization in which the enrollee is enrolled does not require the  
17 provider to be currently participating in the Medicaid program.

18 (2)(a) To be recognized as an authorized provider of visions services, an optometrist  
19 shall:

20 1. Be certified by the:

21 a. Kentucky Board of Optometric Examiners; or

22 b. Optometric examiner board in which the optometrist practices if optometrist prac-  
23 tices in a state other than Kentucky;

1     2. Submit to the department proof of licensure upon initial enrollment in the Kentucky  
2     Medicaid Program; and

3     3. Annually submit to the department proof of licensure renewal including the expira-  
4     tion date of the license and the effective date of renewal.

5     (b)1. To be recognized as an authorized provider of visions services, an in-state opti-  
6     cian shall:

7         a. Hold a current license in Kentucky as an ophthalmic dispenser;

8         b. Comply with the requirements established in KRS Chapter 326;

9         c. Submit to the department proof of licensure upon initial enrollment in the Kentucky  
10        Medicaid Program; and

11        d. Annually submit to the department proof of licensure renewal including the expira-  
12        tion date of the license and the effective date of renewal.

13     2. To be recognized as an authorized provider of visions services, an out-of-state op-  
14     tician shall:

15         a. Hold a current license in the state in which the optician practices as an ophthalmic  
16         dispenser;

17         b. Submit to the department proof of licensure upon initial enrollment in the Kentucky  
18         Medicaid Program; and

19         c. Annually submit to the department proof of licensure renewal including the expira-  
20         tion date of the license and the effective date of renewal.

21     (3)(a) If a procedure is part of a comprehensive service, the department shall:

22         1. Not reimburse separately for the procedure; and

23         2. Reimburse one (1) payment representing reimbursement for the entire

1 comprehensive service.

2 (b) A provider shall not bill the department multiple procedures or procedural codes if  
3 one (1) CPT code or HCPCS code is available to appropriately identify the  
4 comprehensive service provided.

5 (4) A provider shall comply with:

6 (a) 907 KAR 1:671;

7 (b) 907 KAR 1:672; and

8 (c) All applicable state and federal laws.

9 (5)(a) If a provider receives any duplicate or overpayment from the department,  
10 regardless of reason, the provider shall return the payment to the department.

11 (b) Failure to return a payment to the department in accordance with paragraph (a) of  
12 this section may be:

13 1. Interpreted to be fraud or abuse; and

14 2. Prosecuted in accordance with applicable federal or state law.

15 (c) Non-duplication of payments and third-party liability shall be in accordance with  
16 907 KAR 1:005.

17 (d) A provider shall comply with KRS 205.622.

18 (6) The department shall not reimburse for:

19 (a) A service with a CPT code that is not listed on the Department for Medicaid  
20 Services Vision Program Fee Schedule; or

21 (b) An item with an HCPCS code that is not listed on the Department for Medicaid  
22 Services Vision Program Fee Schedule.

23 Section 3. Reimbursement for Covered Procedures and Materials for Optometrists.

(1) Except for~~[With the exception of materials or]~~ a clinical laboratory service, the department's reimbursement for a covered service or covered item provided by a participating optometrist~~[, within the optometrist's scope of licensure,]~~ shall be the:

(a) Lesser of the optometrist's usual and customary charge for the service or item; or

(b) Reimbursement established on the Department for Medicaid Services Vision Program Fee Schedule for the service or item.

(2) The department shall reimburse for a covered clinical laboratory service in accordance with 907 KAR 1:028~~[based on the optometrist's usual and customary actual billed charges up to the fixed upper limit per procedure established by the department using the Kentucky Medicaid fee schedule, specified in 907 KAR 3:010, Section 3, developed from a resource-based relative value scale (RBRVS) on parity with physicians.~~

~~(2) If an RBRVS based fee has not been established, the department shall set a reasonable fixed upper limit for the procedure. The upper limit shall be determined following a review of rates paid for the service by three (3) other sources. The average of these rates shall be compared with similar procedures paid by the department to set the upper limit for the procedure.~~

~~(3) With the exception of the following dispensing services, the department shall use the Kentucky conversion factor for "all nonanesthesia related services" as established in 907 KAR 3:010, Section 3(2)(b)]:~~

~~(a) Fitting of spectacles;~~

~~(b) Special spectacles fitting; and~~

~~(c) Repair and adjustment of spectacles.~~

~~(4) Reimbursement for a dispensing service fee or a repair service fee shall be as~~

follows:

Procedure	Upper Limit
<del>92340 (Fitting of spectacles)</del>	<del>\$33</del>
<del>92341 (Fitting of spectacles)</del>	<del>\$38</del>
<del>92352 (Special spectacles fitting)</del>	<del>\$33</del>
<del>92353 (Special spectacles fitting)</del>	<del>\$39</del>
<del>92370 (Repair &amp; adjust spectacles)</del>	<del>\$29</del>

(5) The department shall:

(a) Reimburse for:

1. A single vision lens at twenty-eight (28) dollars per lens;

2. A bifocal lens at forty-three (43) dollars per lens; and

3. A multi-focal lens at fifty-six (56) dollars per lens; and

(b) Annually adjust the rates established in paragraph (a) of this subsection by the Global Insight Index.

(6)(a) The department shall reimburse for frames or a part of frames (not lenses) at the optical laboratory cost of the materials not to exceed the upper limit for materials as established by the department.

(b) The upper payment limit for frames shall be fifty (50) dollars.

(c) An optical laboratory invoice, or proof of actual acquisition cost of materials, shall be maintained in the recipient's medical records for postpayment review.

(7)(a) Reimbursement for a covered clinical laboratory service shall be based on the

1 ~~Medicare allowable payment rates.~~

2 ~~(b) For a laboratory service with no established allowable payment rate, the payment~~  
3 ~~shall be sixty-five (65) percent of the usual and customary actual billed charges].~~

4 Section 4.~~[3.]~~ Maximum Reimbursement for Covered Procedures and Materials for  
5 Ophthalmic Dispensers. The department's reimbursement for a covered service or cov-  
6 ered item provided by a participating ophthalmic dispenser~~[within the ophthalmic dis-~~  
7 ~~penser's scope of licensure]~~ shall be the:

8 (1) Lesser of the ophthalmic dispenser's usual and customary charge for the service  
9 or item; or

10 (2) Reimbursement established on the Department for Medicaid Services Vision  
11 Program Fee Schedule for the service or item~~[in accordance with Section 2 of this ad-~~  
12 ~~ministrative regulation].~~

13 Section 5.~~[4.]~~ Reimbursement Limitations. (1) The department shall not reimburse  
14 for:

15 (a) A telephone consultation;

16 (b) [shall be excluded from payment.

17 (2)] Contact lenses;

18 (c) [shall be excluded from payment.

19 (3)] Safety glasses unless[shall be covered if] proof of medical necessity is docu-  
20 mented;

21 (d)[-

22 (4) A prism, if medically necessary, shall be added within the cost of the lenses.

23 (5)] A press-on prism; or

1 (e) A service with a CPT code or item with an HCPCS code that is not listed on the  
2 Department for Medicaid Services Vision Program Fee Schedule ~~shall be excluded~~  
3 ~~from payment~~].

4 (2)(a) The department shall reimburse for no more than one (1) pair of eyeglasses  
5 per recipient per twelve (12) consecutive month period unless:

6 1. The recipient's eyeglasses are broken or lost during the twelve (12) consecutive  
7 month period; or

8 2. The eyeglass prescription for the recipient is changed during the twelve (12) con-  
9 secutive month period.

10 (b) If an event referenced in paragraph (a)1 or 2 occurs within the twelve (12) con-  
11 secutive month period, the department shall reimburse for one (1) additional pair of  
12 eyeglasses for the recipient during the twelve (12) consecutive month period.

13 (3) A prism, if medically necessary, shall be included in the cost of lenses.

14 Section 6.~~[5.]~~ Third Party Liability. (1) Nonduplication of payments and third-party lia-  
15 bility shall be in accordance with 907 KAR 1:005.

16 (2) A provider shall comply with KRS 205.622.

17 Section 7. Not Applicable to Managed Care Organizations. (1) A managed care  
18 organization shall not be required to reimburse the same amount as established in this  
19 administrative regulation for an item or service reimbursed by the department via this  
20 administrative regulation.

21 Section 8. Federal Approval and Federal Financial Participation. The department's  
22 reimbursement for services pursuant to this administrative regulation shall be contin-  
23 gent upon:

1 (1) Receipt of federal financial participation for the reimbursement; and

2 (2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

3 Section 9.[6.] Appeal Rights. [(1) An appeal of a negative action taken by the de-  
4 partment regarding a Medicaid beneficiary shall be in accordance with 907 KAR 1:563.

5 (2) An appeal of a negative action taken by the department regarding Medicaid eligi-  
6 bility of an individual shall be in accordance with 907 KAR 1:560.

7 (3)] A provider may appeal a department decision as to the application of this  
8 administrative regulation[An appeal of a negative action taken by the department  
9 regarding a Medicaid provider shall be] in accordance with 907 KAR 1:671.

10 Section 10. Incorporation by Reference. (1) "Department for Medicaid Services Vi-  
11 sion Program Fee Schedule", December 2013, is incorporated by reference.

12 (2) This material may be inspected, copied, or obtained, subject to applicable copy-  
13 right law, at the Department for Medicaid Services, 275 East Main Street, Frankfort,  
14 Kentucky, Monday through Friday, 8 a.m. to 4:30 p.m. or online at the department's  
15 Web site at <http://www.chfs.ky.gov/dms/incorporated.htm>. (21 Ky.R. 218; eff. 9-21-94;  
16 23 Ky.R. 4015; 24 Ky.R. 120; eff. 6-18-97; 27 Ky.R. 1105; eff. 12-21-2000; 34 Ky.R.  
17 1847; 2121; eff. 4-4-08.)

907 KAR 1:631

REVIEWED:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Lawrence Kissner, Commissioner  
Department for Medicaid Services

APPROVED:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Audrey Tayse Haynes, Secretary  
Cabinet for Health and Family Services

## PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing February 14, 2014, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, [tricia.orme@ky.gov](mailto:tricia.orme@ky.gov), Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573.

## REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 1:631  
Cabinet for Health and Family Services  
Department for Medicaid Services  
Agency Contact Person: Stuart Owen (502) 564-4321

- (1) Provide a brief summary of:
  - (a) What this administrative regulation does: This administrative regulation establishes the Department for Medicaid Services' (DMS's) reimbursement provisions and requirements for vision services provided to a Medicaid recipient who is not enrolled in a managed care organization.
  - (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish DMS's reimbursement provisions and requirements for vision services provided to a Medicaid recipient who is not enrolled in a managed care organization.
  - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing DMS's reimbursement provisions and requirements for vision services provided to a Medicaid recipient who is not enrolled in a managed care organization.
  - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statutes by establishing DMS's reimbursement provisions and requirements for vision services provided to a Medicaid recipient who is not enrolled in a managed care organization.
- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
  - (a) How the amendment will change this existing administrative regulation: The amendment incorporates by reference a fee schedule which contains DMS's reimbursement for vision services; establishes that DMS will reimburse for one (1) pair of eyeglasses per year unless the pair is broken or lost or the prescription changes in which case DMS will reimburse for a second pair (currently, DMS in a related administrative regulation has an annual dollar limit of \$200 or \$400 for eyeglasses depending on the recipient's benefit plan); insert various program integrity measures; and establishes that reimbursement is contingent upon receiving federal approval/funding. This amended administrative regulation is being promulgated in conjunction with three (3) other administrative regulations - 907 KAR 1:632, Vision Program coverage provisions and requirements; 907 KAR 1:038, Hearing program coverage provisions and requirements; and 907 KAR 1:039, Hearing Program reimbursement provisions and requirements. 907 KAR 1:039 currently contains the \$200 and \$400 annual limit on eyeglasses, but vision program provisions are being removed from that administrative regulation as they will be addressed in this administrative regulation.

- (b) The necessity of the amendment to this administrative regulation: Establishing a limit of one (1) pair of eyeglasses [or two (2) if the first pair is lost or the recipient's prescription changes] per year rather than an annual dollar cap (\$200 or \$400 as is currently stated in a related administrative regulation) is necessary to comply with an Affordable Care Act mandate. The mandate prohibits, effective January 1, 2014, annual dollar limits on health insurance benefits that are "essential health benefits." Medicaid program benefits are included in the scope of essential health benefits. Establishing that the provisions in this administrative regulation are contingent upon the receipt of federal approval and federal funding is necessary to protect Kentucky taxpayer monies from being used if federal matching funding is not being provided. Additional amendments are necessary to incorporate various program integrity measures; clarify provisions and requirements; and to provide a user friendly fee schedule of reimbursement.
  - (c) How the amendment conforms to the content of the authorizing statutes: The amendment will conform to the content of the authorizing statutes by complying with a federal mandate; by preventing a potential loss of state funds; by inserting program integrity measures; and by clarifying provisions and requirements.
  - (d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by complying with a federal mandate; by preventing a potential loss of state funds; by inserting program integrity measures; and by clarifying provisions and requirements.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect vision service providers participating in the Kentucky Medicaid program. For calendar year 2012, twenty-two (22) opticians billed the Medicaid program [either a managed care organization or "fee-for-service Medicaid (non-managed care)] for services rendered and 614 optometrists billed claims to the Medicaid program. 7,298 individuals (managed care and fee-for-service combined) received services from opticians in calendar year 2012 and 187,896 individuals received services from optometrists (managed care and fee-for-service combined) during the same period.
- (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
- (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. No action is required of the regulated entities other than properly billing for services and not violating program integrity requirements.
  - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed on the regulated entities.
  - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients may benefit by being allowed to have a pair of

eyeglasses per year (with an additional pair allowed if the first pair is lost or the recipient's prescription changes) rather than be subject to a \$200 or \$400 annual cap on eyeglasses. Providers will benefit from a user friendly fee schedule.

- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
  - (a) Initially: In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid \$9,139 in claims to opticians and Medicaid managed care organizations paid \$548,235 in claims to opticians. For the same period DMS paid \$696,300 in claims to optometrists and Medicaid managed care organizations paid \$19,096,123 in claims to optometrists.
  - (b) On a continuing basis: DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act, state matching funds, and agency appropriations.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No increase in funding will be necessary to implement this administrative regulation.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor directly nor indirectly increases any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is applied as eyeglass coverage is only available to those under twenty-one (21). 42 C.F.R. 441.56(c)(1) – which addresses early and periodic screening, diagnosis and treatment (EPSDT) services coverage – mandates coverage for individuals under twenty-one (21).

## FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation Number: 907 KAR 1:631

Agency Contact Person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. 447.201, 42 C.F.R. 447.204, 42 C.F.R. 441.56(c)(1), 42 C.F.R. 441.30, Section 2711 of the Affordable Care Act, and 45 C.F.R. 147.126.
2. State compliance standards. KRS 194A.050(1) states, "The secretary shall promulgate, administer, and enforce those administrative regulations necessary to implement programs mandated by federal law, or to qualify for the receipt of federal funds and necessary to cooperate with other state and federal agencies for the proper administration of the cabinet and its programs."

KRS 205.520(3) states: "... it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. Vision services are not federally mandated except for those under age twenty-one (21) via the early and periodic screening, diagnosis and treatment (EPSDT) services for individuals under age twenty-one (21) program pursuant to 42 C.F.R. 441.56(c)(1).

42 C.F.R. 441.30 states, "The plan must provide for payment of optometric services as physician services, whether furnished by an optometrist or a physician, if—  
(a) The plan does not provide for payment for services provided by an optometrist, except for eligibility determinations under §§435.531 and 436.531 of this subchapter, but did provide for those services at an earlier period; and  
(b) The plan specifically provides that physicians' services include services an optometrist is legally authorized to perform."

Medicaid reimbursement for services is required to be consistent with efficiency, economy and quality of care and be sufficient to attract enough providers to assure access to services. 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to: "... provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

45 C.F.R. 147.126 prohibits the application of annual dollar limits on essential health benefits. Medicaid program benefits are included in the scope of essential health benefits.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.

## FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 1:631

Agency Contact Person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services (DMS) will be affected by the administrative regulation.
2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. 441.30, 42 C.F.R. 441.56(c)(1), .
3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
  - (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS expects that the amendment will not generate revenue.
  - (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS expects that the amendment will not generate revenue.
  - (c) How much will it cost to administer this program for the first year? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid \$9,139 in claims to opticians and Medicaid managed care organizations paid \$548,235 in claims to opticians. For the same period DMS paid \$696,300 in claims to optometrists and Medicaid managed care organizations paid \$19,096,123 in claims to optometrists. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.
  - (d) How much will it cost to administer this program for subsequent years? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid \$9,139 in claims to opticians and Medicaid managed care organizations paid \$548,235 in claims to opticians. For the same period DMS paid \$696,300 in claims to optometrists and Medicaid managed care organizations paid \$19,096,123 in claims to optometrists. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): \_\_\_\_\_

Expenditures (+/-): \_\_\_\_\_

Other Explanation:

COMMONWEALTH OF KENTUCKY  
CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:631

Summary of Material Incorporated by Reference

The “Department for Medicaid Services Vision Fee Schedule”, December 2013, is incorporated by reference. This four (4)-page document displays reimbursement for vision services.